Washington State
RSN, Provider, & Key Stakeholder

PACT Training

February 2, 2007

Maria Monroe-DeVita, Ph.D.
The Washington Institute for Mental Illness Research & Training
University of Washington

What today holds for us…

To learn about...

- What PACT is
- Common implementation challenges & how to effectively deal with them
- Our plans for training and technical assistance
- The importance of and plans for evaluation

A Brief History of PACT

- Late 1960's at Mendota State Hospital, Madison, WI
- Stein & Test (1980): Successfully transferred the functions of an inpatient psychiatric unit into the community
- Earlier called the Training in Community Living model; later became Program of Assertive Community Treatment (PACT)
- Also known by many other names: ACT, continuous treatment teams, mobile treatment teams, assertive outreach

What is PACT?

- A team-based approach to community-based mental health services
- For individuals with severe & persistent mental illness
- Provides array of treatment, rehabilitation, and support services
- Focus is on the full range of individuals' biopsychosocial needs in the community
  - ✓ Obtaining housing
  - ✓ Securing benefits
  - ✓ Community activities
  - ✓ Improving skills
  - ✓ Working with families
  - ✓ Gaining employment

Who is best served by PACT?

Individuals in “greatest need:”

- Severe and persistent mental illness
  - Priority typically given to schizophrenia-spectrum disorders and bipolar disorder
- Significant difficulty in doing day-to-day tasks needed to live independently in the community
  - e.g., maintaining employment and/or housing, care for medical or nutritional needs, meeting own personal financing needs
- Continuous high service needs
  - e.g., high use of inpatient or crisis services, long duration of substance use, criminal justice involvement

Key Components of PACT Today

Adapted from Morse & McKasson, 2005

1. Transdisciplinary team
2. Team approach/ shared caseload
3. Specific admission criteria
4. Primary provider of services
5. Comprehensive care
6. Intensive services
7. Services provided in-vivo
8. Individualized services
9. Assertive, yet flexible
10. Open-ended service*
11. Person-centered*
12. Recovery-oriented*
13. Work with natural supports

Typical PACT Services

- Service coordination
- Crisis assessment & intervention
- Integrated co-occurring disorders treatment
- Vocational services
- Peer support
- Wellness psychoeducation and management
- Working with families & natural supports
- Symptom assessment & management
- Medication prescription, administration, monitoring
- Housing acquisition and maintenance
- Daily activities
- Community & social integration

PACT has been widely promoted

- **1996:** NAMI began promoting PACT in all 50 states
- **1998:** The Schizophrenia PORT Study recommended PACT. Identified as one of six Evidence-Based Practices (EBPs) by RWJ expert panel.
- **1999:** Promoted by the U.S. Surgeon General. HCFA (now CMS) authorized PACT as a Medicaid-reimbursable service.
- **2000-2005:** Focus within the National EBP Project, SAMHSA Toolkits and 1 of 3 indicators of quality in state mental health systems, President's New Freedom Commission.
- **Today:** Efforts to ensure that PACT is implemented as intended. Person-centered & recovery-oriented approaches are front & center.

PACT Dissemination

- 1996: 396 PACT Teams in 34 states
  - Early adopters: WI, RI, DE, NH, CT, SC, MI
  - Recent adopters: IL,TX, NJ, NY,FL (Meisler, 1996)
- 2003: 36 (out of 48 responding) states funded or operated approximately 440 total PACT or PACT-like programs.
  - Range per state = 1 (LA, OR, WA) to 72 (NY)
  - Median per state = 7 PACT programs

(NASMHPD, 2004)

PACT Dissemination (cont.)

- 2003: 41 (out of 48 responding) states reported providing PACT or PACT-like services
  - 11 states: statewide
  - 27 states: implemented in parts of state
  - 6 states: piloted or planned (NASMHPD, 2004)
- Exemplar programs in 2007:
  - Oklahoma
  - Madison and Green County, WI
  - Some programs in Indiana

International PACT Dissemination

- Australia
- Canada
- United Kingdom
- Sweden
- And now most recently...Japan

PACT Financing

- 36 states (out of 48 responding): Medicaid
  - 29 states use the Rehab Option
  - 5 states use 1915(b) Waiver
  - 3 states use the Clinic Option
  - 4 states use 1115 Waiver
- 34 states: State General Funds
- 16 states: Block Grant Funds
- 11 states: Local Funds

(NASMHPD, 2004)

PACT has been widely studied

- Over 50 published empirical studies -- at least 25 are RCTs
- Several reviews and meta-analyses of PACT research (e.g., Bond et al., 2001; Marshall & Creed, 2000; Monroe-DeVita & Mohatt, 2000; Mueser et al., 1998)
- Studies vary on details regarding “what” was actually delivered
- All indicate some degree of improved community integration for PACT clients

What the data say across studies

- PACT's most robust outcomes:
  - ✓ Decreased hospital use
  - ✓ More independent living & housing stability
  - ✓ Retention in treatment
  - ✓ Consumer and family satisfaction

- Moderate outcomes:
  - ✓ Reduced psychiatric symptoms
  - ✓ Improved quality of life

Weaker evidence in these areas

- Vocational improvement/employment
- Social adjustment/functioning
- Substance use
- Criminal justice system involvement

Suggests the need for targeting these areas in PACT service delivery – significant implications for targeted training

Cost-effectiveness of PACT

- Original PACT study
  - Small economic advantage over hospital-based care (Weisbrod, Test, & Stein, 1980)
- Latimer (1999) reviewed 34 PACT programs and found that PACT is cost-effective when:
  - Services are targeted toward persons who are high users of inpatient psychiatric services (>50 hospital days in prior year)
  - It is implemented with high fidelity to the PACT model

What consumers say about PACT

- What do you like?
  - Helping relationship & staff attributes were highest endorsed
  - Team approach seldom mentioned
  - Therapeutic relationship related to consumer satisfaction

(McGrew et al., 1996)

- What do you dislike?
  - Most disliked “nothing”
  - PACT-specific issues
  - Insufficient PACT
  - More general complaints about system
  - The higher the fidelity, the fewer the complaints

(McGrew et al., 2002)

What PACT Providers say about PACT

- Top 10 ingredients:
  - Nursing role is helpful
  - Involvement in hospitalization
  - FT social work-type role
  - Shared treatment planning
  - Small caseloads/low staff-consumer ratio
  - Services in community
  - Clearly identified admission criteria
  - Daily meetings (McGrew & Bond, 1997a)
- PACT provider burnout (vs. case manager):
  - Less emotional exhaustion
  - More personal accomplishment (Boyer & Bond, 1999)

Next Steps

- Prioritize recovery training and ongoing education for all PACT staff and consumers *(training & TA, contract)*
- Ensure that all clinical training in evidence-based approaches is person-centered & recovery-oriented *(training & TA, contract)*
- Promote and monitor full integration of peer specialists on the team; provide mechanism for ongoing mutual support

  (training & TA, Standards, evaluation)

Next Steps

- Support local PACT Stakeholder Advisory Group membership, participation, and ongoing feedback *(Standards, contract, training & TA)*
- Incorporate assessment of recovery processes into fidelity tool *(evaluation)*
- Evaluate consumer recovery as part of outcome assessment *(evaluation)*
- Ensure psychiatric rehabilitation service approaches *(Standards, training & TA, evaluation)*

Next Steps

- Ongoing monitoring of appropriate authorization, admission, and prioritization processes *(Standards, evaluation, TA, contract)*
- Staff training in cultural competence; Ongoing monitoring of Culturally and Linguistically Appropriate Services (CLAS) *(training & TA, Standards, contract)*
- Training and TA in housing acquisition and retention *(training & TA, contract)*

PACT Implementation
Challenges and Opportunities

Presented by Rachel Post, L.C.S.W.

rpost@centralcityconcern.org, (503) 929-7799

Consumer and Family Involvement

- Primary stakeholders to be involved at every level- these are our first hand informants.
- Advisory Board participation includes evaluation of implementation, ongoing program outcomes, compliance and quality improvement.
- Avoiding tokenism: assure these partners are equal members who have a say in performance indicators and that consumer provider is equal team member.
- Must hold rest of participants accountable to being inclusive and seeing experience through the eyes of consumers and families.

Administrative challenges and opportunities

- $$$$$$- fully funded multi-disciplinary team, competitive salaries, consumer needs funds, housing.
- Design and location of team space
- Operationalizing program goals and objectives and performance indicators
- Collaboration across multiple service systems (SSA, Hospitals, Property Managers, Housing Authority, Vocational Rehabilitation, Employers, Family and Consumer Advocates, Mental Health Division, Health Department, Community Justice, Addiction Treatment Providers, PACT teams)

Administrative challenges and opportunities

- Communication of program values and principles- consumer choice, strength's orientation, recovery
- Selection of all staff RSN and Team Leads, RNs, Psychiatrist, Case Managers, Peer Specialist, etc.
- Documentation and evaluation of program
- Dissemination of findings
- Staff tenure

Clinical challenges and opportunities

- Interviewing candidates- questions should reflect values and principles of recovery
- Selection of staff- good candidates can think outside the box, communicate belief in recovery for all, exude energy, enthusiasm and hope, speak in "people first language", do not use "compliance", "manipulative", "cooperate".

Clinical challenges and opportunities

- Sometimes less seasoned staff are more moldable.
- Commitment to “Whatever it takes”.
- Training: PACT, Crisis intervention, Cultural competence, Motivational Interviewing, Strengths planning, DBT, Trauma informed, Compassion Fatigue, WRAP, Advanced Directives, Debriefings, etc.
- Maintaining team approach and communication

Clinical challenges and opportunities

- Maintaining **in vivo** service delivery(not just in people's homes). This will be new to most staff.
- Overcoming iatrogenic effects: trauma, stigma (by system and self imposed), homeless, criminal justice- LA County, institutionalized, dreams never materialized, etc.- Patrick McCorry's model of Early Psychosis Prevention and Intervention (EPPIC)
- Cultivation of team is ongoing- celebrate consumer and staff successes.
- Sustaining staff energy, innovation and hope.

Clinical challenges and opportunities

- Engaging consumers, even those who are civilly committed.
- Consumer providers are equal partners
- Cultural competency
- True community integration- employment, social network outside mh system, etc.
- People first language
- Staff safety.

Clinical challenges and opportunities

- Dealing with death- debriefing.
- Payeeship.
- Staff respectfully challenging one another.
- Patience- engagement takes time. Allow people to make decisions we aren't comfortable with. They will have set backs and these can be learning experiences for staff and consumers.

Clinical challenges and opportunities

- Titrating down service level as appropriate.
- Avoid doing for others what they can do for themselves. Every encounter is an opportunity for learning, both for staff and consumers.
- Using encounter data to track fidelity to model: location of service, frequency of encounters, team share, etc.
- Treating participants as people, not patients.

Getting to PACT…

PACT
Training & Technical Assistance

“Successful programs do not contain the seeds of their own replication.”

- Schorr, 1993

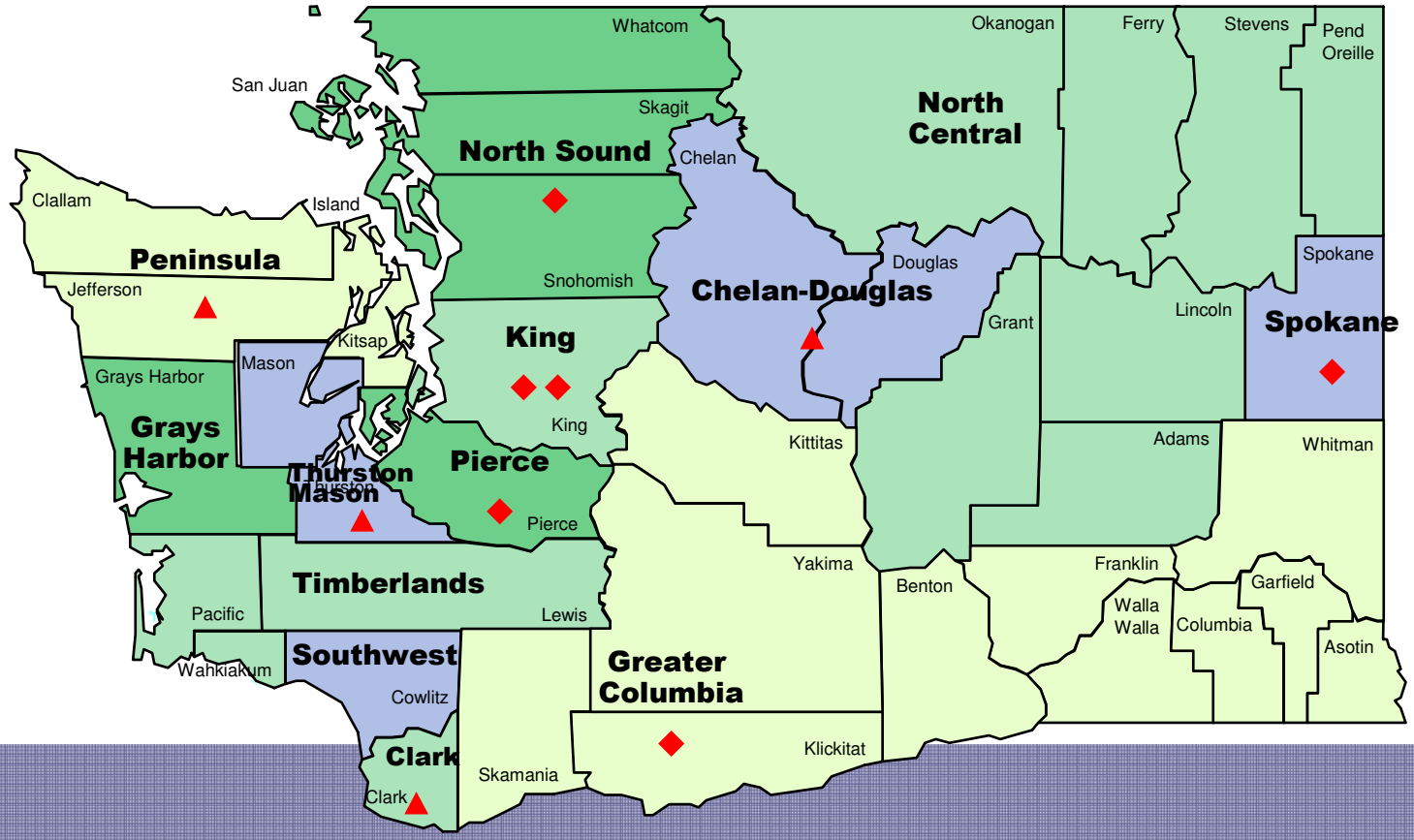
Planned Implementation of PACT Teams in Washington State

13 Regional Support Networks (RSNs)

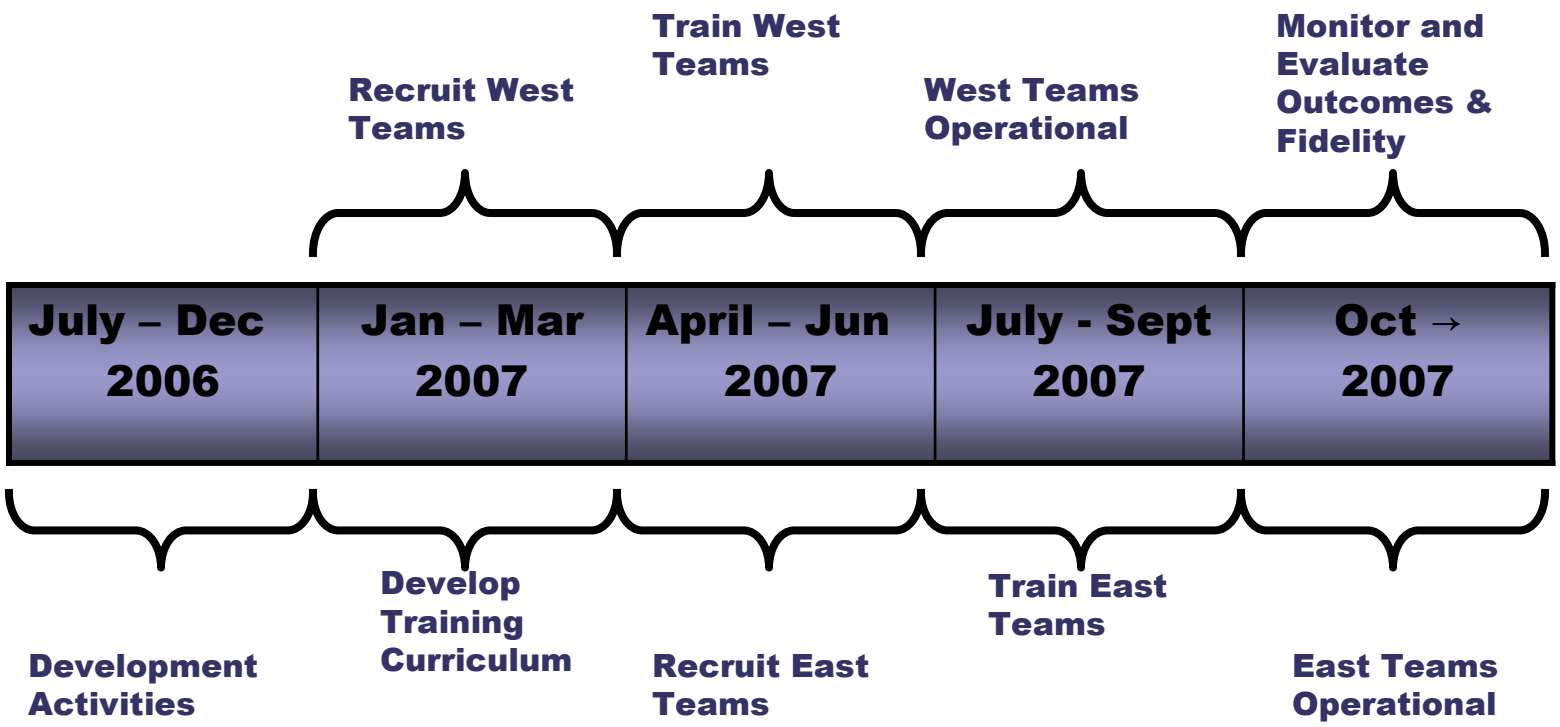
Effective 9/2006

◆ = Full Team

▲ = Half Team



PACT Implementation Timeline



Training & TA Plan is driven by…

1. Training and implementation literature
2. Direct experience with PACT implementation
3. Feedback from key stakeholders (STI Task Force & Community Forums)
4. Feedback from you today
5. Ongoing feedback throughout implementation

Overarching Principles

(Fixsen et al., 2005)

- Information by itself is ineffective
- Training alone doesn't work; however…
- Training paired with…
  - Demonstration or modeling (live or taped)
  - Behavioral rehearsal & feedback
  - Ongoing coaching and consultation

  …DOES work.
- Ongoing performance assessment is essential

Overarching Principles

- Too much, too quickly doesn't get absorbed
- Need to focus on PACT-specific skills first, then add in the others
- Recovery is central to all training provided
- Need to individually tailor when possible based on different implementation timelines, strengths, challenges & resources
- This is a collaboration with YOU!

Stage 1: Identify Early TA Needs, Initial Training and Phone TA

1. Feedback on "implementation plans"/ identification of initial training & technical assistance needs

Western PACT	12/06 – 1/07
Eastern PACT	2/07 – 3/07

2. RSN Training & PACT Implementation Handbook

Western PACT	2/2/07
Eastern PACT	

3. PACT Start-Up TA Calls
4. Housing TA Calls

Western PACT	2/07 – 7/07
Eastern PACT	2/07 – 7/07

Stage 2: Learn from Others

5. Visit existing PACT teams
   - ✓ Wisconsin
   - ✓ Oklahoma

Western PACT	1st Wave	3/07 – 5/07
	2nd Wave	5/07 – 7/07
Eastern PACT		7/07 – 9/07

- Current funding to support airfare, hotel, and meals for up to three people from the 7 Western PACT teams
- Anticipate funding for similar support in next state fiscal year for the 3 Eastern Teams

Stage 2: Learn from Others (cont.)

6. Plan to establish a listserv for Washington PACT teams and stakeholders involved in PACT implementation

Western PACT	Anticipated 5/07 – 6/07
Eastern PACT	

Stage 3: PACT Start-Up Training

7. PACT Kick-off Meeting & Focused Training on:
   - ✓ PACT Overview
   - ✓ Recovery
   - ✓ Housing
   - ✓ Cultural Competency
   - ✓ Team Roles

8. Two-day individualized PACT Start-Up Training provided on-site

Western PACT	1st Wave	4/07 to 5/07
	2nd Wave	Late 5/07 to early 6/07
Eastern PACT		7/07 or 8/07

Stage 4:
Training in Other Key Areas

9. Strengths-Based Assessment & Person-Centered Planning/ Integration of Peer Specialists

10. Co-Occurring Disorders Training

11. Vocational Training

Western PACT	1st Wave	5/07 – 6/07
	2nd Wave	6/07 – 7/07
Eastern PACT		8/07 - 10/07

Stage 5: Ongoing Consultation & Follow-Up Booster Training

12. Follow-up phone consultation after implementation 1-2 times a month for each PACT team

13. Two-day individualized PACT booster training provided on-site

Western PACT	5/07 – 1/08+
Eastern PACT	10/07 – 1/08+

Western PACT	1st Wave	11/07 – 12/07
	2nd Wave	1/08
Eastern PACT		2/08 – 3/08

Stage 6: Ongoing Mutual Support & Cross-Training

14. Team Leaders' Meeting/Training

15. Peer Specialists' Meeting/Training

16. Other Specialists' Meeting/Training

17. Team Forum

Western PACT	To Be Determined
Eastern PACT	

Stage 7: Tailor Ongoing Training & TA Based on Emerging & Ongoing Needs

18. Ongoing Housing phone consultation
19. Follow-up Training in Vocational Services, Co-Occurring Disorders, Strengths-Based Assessment & Person-Centered Planning
20. Other Training (Criminal Justice Issues, Working with Natural Supports, Cultural Competency)

Western PACT	To Be Determined
Eastern PACT	

How will we know it's implemented & making a difference?

PACT Evaluation

The Gap Between Science & Service

- Well-documented support for evidence-based practices (EBPs):
  - e.g., PORT Study (1998, 2003); RWJ Consensus Panel (1998); APA Task Force (1998); NREPP (current)
- Also well-documented that many treatments known to work are not implemented:
  - Surgeon General (1999)
  - Institute of Medicine (2001, 2006)
  - New Freedom Commission (2003)
  - Take a look around…

…Thus the need to evaluate the process of implementation

- Implementation Factors: *Elements, components, variables that affect program implementation*
- More specifically, these factors have an impact on the extent to which implementation is successful
- Examples: Funding for the program, training and consultation, leadership to promote and implement the program

Process Evaluation: Why it's important for WA PACT

- Much $$ has been spent on this program
- We want to ensure that we are closely monitoring factors that both facilitate and hinder successful implementation
- Information collected will be helpful to ongoing training and implementation efforts

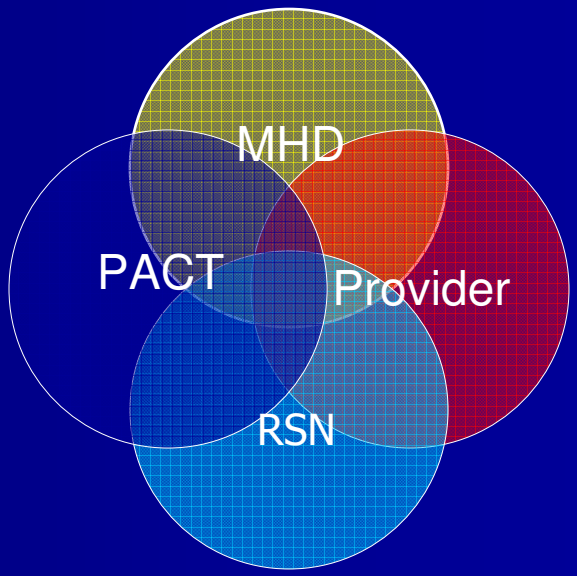
Key Considerations

Implementation is a *process*

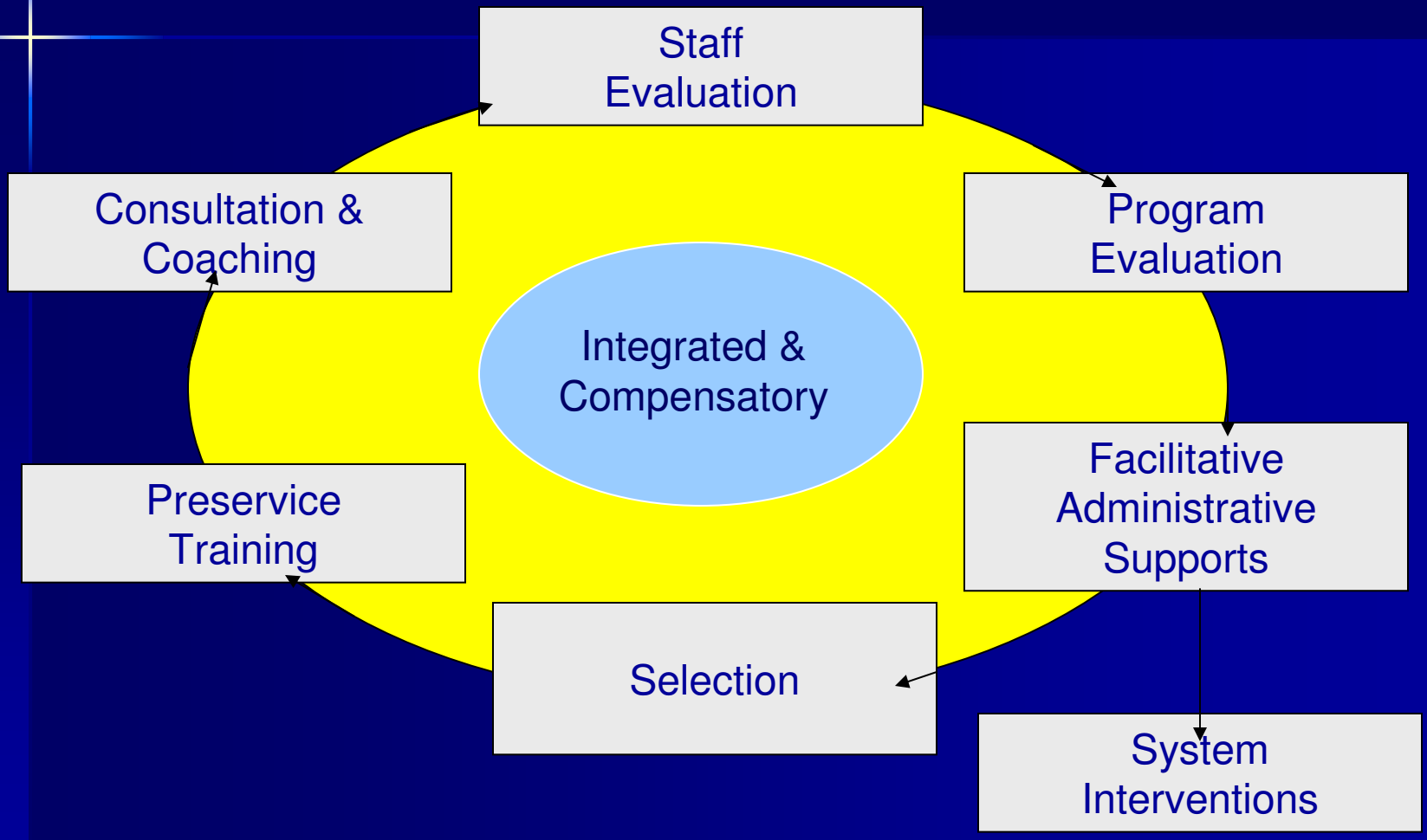
(Fixsen et al., 2005)

- **Exploration & Adoption**
- **Program Installation**
- **Initial Implementation**
- **Full Operation**
- **Innovation**
- **Sustainability**

Implementation occurs at *multiple levels*



One Model of Implementation



Fixsen et al., 2005

Other factors to consider at multiple levels

- Infrastructure
- Financing
- Leadership
- Staffing consistency
- Policies
- Workflow
- Organizational readiness
- Organizational climate/culture
- Etc.

WA PACT Process Evaluation

- Working in collaboration with WIMIRT-E
- Will develop various strategies for tracking several key factors at multiple levels and over time
- Factors will be examined routinely to inform & improve ongoing implementation and training

The Value of Program Fidelity

...the extent to which program practices adhere to the principles of the intended program model

- Necessary to ensure internal validity
- Critical for replication
- Essential for true interpretation of outcome
- Identify/prevent model drift
- Useful for program monitoring

The Value of PACT Fidelity

- Consumers and staff in PACT programs with greater fidelity experienced better outcomes
- In McGrew, Bond, et al. (1994), reduced hospital use was correlated with:
  - Shared caseloads
  - Nurse on team
  - Daily team meetings
  - Team leader as practicing clinician
  - Total contacts

The Value of PACT Fidelity
(McHugo, Drake, et al., 1999)

- Examined consumer outcomes in 7 PACT teams
- Consumers served by high fidelity PACT teams experienced:
  - Fewer hospitalizations
  - Fewer treatment dropouts
  - Greater remission from substance use

Approaches to PACT Fidelity Measurement

- Comparison between PACT team and state's PACT program standards (e.g., Oklahoma)
- Model Fidelity Review of the National ACT Standards (Allness & Knoedler, 2003)
- Dartmouth ACT Fidelity Scale (DACTS; Teague et al., 1998)

The DACTS
(Teague et al., 1998)

- Includes 28 items
- Assesses structure, staffing, organizational components, and nature of services
- Anchored ratings between 1 (“not implemented”) and 5 (“fully implemented”)
- Ratings based on *current* activities and status
- Completed by internal agency or team OR by external reviewers

DACTS Items

Human Resources: Structure & Composition

- Small Caseload
- Team Approach
- Program Meeting
- Practicing Team Leader
- Continuity of Staffing
- Staff Capacity
- Psychiatrist on Staff
- Nurse on Staff
- Substance Abuse Specialist on Staff
- Vocational Specialist on Staff
- Sufficient Program Size

DACTS Items

Organizational Boundaries

- Explicit Admission Criteria
- Low Intake Rate
- Fully Responsible for Treatment Services
- Responsible for Crisis Services
- Responsible for Hospital Admissions
- Responsible for Hospital Discharge Planning
- Time-Unlimited Services

DACTS Items

Nature of Services

- Community-Based Services
- No Dropout Policy
- Assertive Engagement Mechanisms
- High Service Intensity
- High Frequency of Contacts
- Work with Informal Support System
- Individualized Substance Abuse Treatment
- Dual Disorder Treatment Groups
- Dual Disorders Model
- Consumers on Team

DACTS Example Items

Domain	1	2	3	4	5
Small Caseload	50 clients per team member or more	35-49	21-34	11-20	10 clients per team member or fewer

DACTS Example Items

Domain	1	2	3	4	5
Responsible for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

Limitations of the DACTS

- Mainly assesses structure, not processes within the team
- Original purpose to assess a COD-ACT team
- Doesn't match up with National Standards
- Outdated – nothing about recovery processes

WA State Fidelity Assessment

- Use the DACTS template and approach
- Crosswalk WA PACT Standards with DACTS
- Include items related to core processes within PACT (e.g., team communication, services)
- Add items that assess recovery approaches, Peer Specialist role, person-centered planning
- Ask consumers and natural supports
- Use for ongoing performance improvement and supervision

WA State Outcome Assessment

- Will be conducted by MHD
- Builds on those outcomes important from both a PACT and a recovery perspective
- MHD will be laying these out in more detail as plans are further developed

For More PACT Training & TA Information:

Maria Monroe-DeVita, Ph.D.
WIMIRT/University of Washington
146 N. Canal Street, Suite 100
Seattle, WA 98103
(206) 384-7372
mmdv@u.washington.edu